

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045350

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11787

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

FILED DEC 5 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 50 yrs.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 3447 Geraldine	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph L. Dalton		4. DATE OF DEATH Month Day Year 11 26 63	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/3/86
9. AGE (last birthday) 77		10. IF UNDER 1 YEAR 10 mos 23 hrs	
11. IF UNDER 24 HR Hours Min.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME DANIEL DALTON		13b. MOTHER'S MAIDEN NAME SARAH BARKER	
14. NAME OF HUSBAND OR WIFE SUSIE ANN DALTON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) YES WW I	
16. SOCIAL SECURITY NO.		17. INFORMANT ANGIE D. WHITMORE, 3447 Geraldine	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bilateral Staghorn Renal Calculi DUE TO (c) 602x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 10-29-63 to 11-26-63 and last saw him alive on 11-26-63 Death occurred at 6:55 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Merle B. Humphreys M.D.		22b. ADDRESS 2601 N. Whittier	
22c. DATE SIGNED 11-27-63		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 12/2/63		23c. NAME OF CEMETERY OR CREMATORY National Cemetery	
23d. LOCATION (City, town, or county) St. Louis County, Mo.		(State)	
24. FUNERAL DIRECTOR Charles J. Gates, Jr., 4107 Finney		25. DATE RECD. BY LOCAL REG. NOV 29 1963	
26. REGISTRAR'S SIGNATURE Earl Smith M.D.			

PC8540-002

EX-11

2004

2004

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Guylton Lewis

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.